

**Consent for Communication and Information Sharing Between School and Health Care Teams**

STUDENT NAME: \_\_\_\_\_ STUDENT DOB: \_\_\_\_\_

HEALTH CARE PROVIDER: Timber Lane Pediatrics, Primary Care Health Partners

SCHOOLNAME/DISTRICT: \_\_\_\_\_

EMBEDDED SCHOOL MENTAL HEALTH ENTITY: \_\_\_\_\_

**FERPA Consent to Allow Data Sharing from School to Health Care**

- I give permission to my child’s school to share information with and discuss my child’s health and school performance with my child’s health care team as needed and as permitted by law
  - I understand that allowing my child’s school to share information with my child’s health care team will allow them to coordinate my child’s care, provide outreach services if necessary, and keep my child healthy, safe, and engaged in school
  - I understand that, even with this consent, only those individuals at my child’s health care office and school who must have access to information about my child to provide necessary services will be permitted to participate in discussions or data sharing regarding my child
  - I understand that, whenever possible, my school will include me in discussions about my child.
  - I understand that I am entitled to receive a copy of any disclosed records.
  - I understand that these individuals may further use records provided by my child’s school or healthcare provider for contacting me and/or verifying information for student health related purposes.
- I understand that my consent to allow sharing the above information is voluntary and that it is not required for my child to enroll in school or to seek care at my child’s doctor. This consent will remain in effect for as long as my child is enrolled in this school district. I understand that I may revoke this consent at any time by submitting a note or letter in writing to the school administration office.

Parent/Guadian Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**HIPAA Consent to Allow Data Sharing from School to Health Care**

- I give permission to my child’s school to share information with and discuss my child’s health and school performance with my child’s health care team as needed and as permitted by law
- I understand that allowing my child’s school to share information with my child’s health care team will allow them to coordinate my child’s care, provide outreach services if necessary, and keep my child healthy, safe, and engaged in school
- I understand that, even with this consent, only those individuals at my child’s health care office and school who must have access to information about my child to provide necessary services will be permitted to participate in discussions or data sharing regarding my child
- I understand that, whenever possible, my school will include me in discussions about my child.
- I understand that I am entitled to receive a copy of any disclosed records.
- I understand that these individuals may further use records provided by my child’s school or healthcare provider for contacting me and/or verifying information for student health related purposes.

I understand that my consent to allow sharing the above information is voluntary and that it is not required for my child to enroll in school or to seek care at my child’s doctor. This consent will remain in effect for as long as my child is enrolled in this school district. I understand that I may revoke this consent at any time by submitting a note or letter in writing to the school administration office.

Parent/Guadian Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_